

Wyeth Pharmaceuticals

Effexor (immediate release) Prescribing Information
August 2003



Effexor[®]

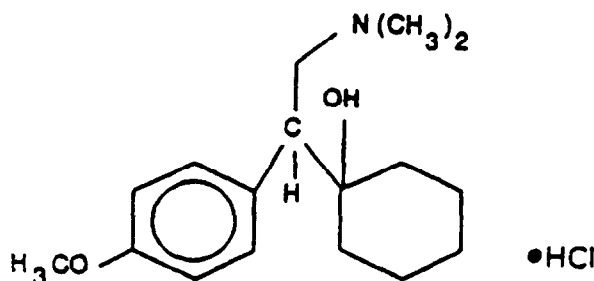
(venlafaxine hydrochloride)

Tablets

R_x only

DESCRIPTION

Effexor (venlafaxine hydrochloride) is a structurally novel antidepressant for oral administration. It is chemically unrelated to tricyclic, tetracyclic, or other available antidepressant agents. It is designated (R/S)-1-[2-(dimethylamino)-1-(4-methoxyphenyl)ethyl] cyclohexanol hydrochloride or (±)-1-[α-[(dimethyl-amino)methyl]-p-methoxybenzyl] cyclohexanol hydrochloride and has the empirical formula of C₁₇H₂₇NO₂ HCl. Its molecular weight is 313.87. The structural formula is shown below.



venlafaxine hydrochloride

Venlafaxine hydrochloride is a white to off-white crystalline solid with a solubility of 572 mg/mL in water (adjusted to ionic strength of 0.2 M with sodium chloride). Its octanol: water (0.2 M sodium chloride) partition coefficient is 0.43.

Compressed tablets contain venlafaxine hydrochloride equivalent to 25 mg, 37.5 mg, 50 mg, 75 mg, or 100 mg venlafaxine. Inactive ingredients consist of cellulose, iron oxides, lactose, magnesium stearate, and sodium starch glycolate.

CLINICAL PHARMACOLOGY

Pharmacodynamics

The mechanism of the antidepressant action of venlafaxine in humans is believed to be associated with its potentiation of neurotransmitter activity in the CNS. Preclinical studies have shown that venlafaxine and its active metabolite, O-desmethylvenlafaxine (ODV), are potent inhibitors of neuronal serotonin and norepinephrine reuptake and weak inhibitors of dopamine reuptake. Venlafaxine and ODV have no significant affinity for muscarinic, histaminergic, or α-1 adrenergic receptors in vitro. Pharmacologic activity at these receptors is hypothesized to be associated with the various anticholinergic, sedative, and cardiovascular effects seen with other

psychotropic drugs. Venlafaxine and ODV do not possess monoamine oxidase (MAO) inhibitory activity.

Pharmacokinetics

Venlafaxine is well absorbed and extensively metabolized in the liver. O-desmethylvenlafaxine (ODV) is the only major active metabolite. On the basis of mass balance studies, at least 92% of a single dose of venlafaxine is absorbed. Approximately 87% of a venlafaxine dose is recovered in the urine within 48 hours as either unchanged venlafaxine (5%), unconjugated ODV (29%), conjugated ODV (26%), or other minor inactive metabolites (27%). Renal elimination of venlafaxine and its metabolites is the primary route of excretion. The relative bioavailability of venlafaxine from a tablet was 100% when compared to an oral solution. Food has no significant effect on the absorption of venlafaxine or on the formation of ODV.

The degree of binding of venlafaxine to human plasma is $27\% \pm 2\%$ at concentrations ranging from 2.5 to 2215 ng/mL. The degree of ODV binding to human plasma is $30\% \pm 12\%$ at concentrations ranging from 100 to 500 ng/mL. Protein-binding-induced drug interactions with venlafaxine are not expected.

Steady-state concentrations of both venlafaxine and ODV in plasma were attained within 3 days of multiple-dose therapy. Venlafaxine and ODV exhibited linear kinetics over the dose range of 75 to 450 mg total dose per day (administered on a q8h schedule). Plasma clearance, elimination half-life and steady-state volume of distribution were unaltered for both venlafaxine and ODV after multiple-dosing. Mean \pm SD steady-state plasma clearance of venlafaxine and ODV is 1.3 ± 0.6 and 0.4 ± 0.2 L/h/kg, respectively; elimination half-life is 5 ± 2 and 11 ± 2 hours, respectively; and steady-state volume of distribution is 7.5 ± 3.7 L/kg and 5.7 ± 1.8 L/kg, respectively. When equal daily doses of venlafaxine were administered as either b.i.d. or t.i.d. regimens, the drug exposure (AUC) and fluctuation in plasma levels of venlafaxine and ODV were comparable following both regimens.

Age and Gender

A pharmacokinetic analysis of 404 venlafaxine-treated patients from two studies involving both b.i.d. and t.i.d. regimens showed that dose-normalized trough plasma levels of either venlafaxine or ODV were unaltered due to age or gender differences. Dosage adjustment based upon the age or gender of a patient is generally not necessary (see **DOSAGE AND ADMINISTRATION**).

Liver Disease

In 9 patients with hepatic cirrhosis, the pharmacokinetic disposition of both venlafaxine and ODV was significantly altered after oral administration of venlafaxine. Venlafaxine elimination half-life was prolonged by about 30%, and clearance decreased by about 50% in cirrhotic patients compared to normal subjects. ODV elimination half-life was prolonged by about 60% and clearance decreased by about 30% in cirrhotic patients compared to normal subjects. A large degree of intersubject variability was noted. Three patients with more severe cirrhosis had a more substantial decrease in venlafaxine clearance (about 90%) compared to normal subjects.

Dosage adjustment is necessary in these patients (see **DOSAGE AND ADMINISTRATION**).

Renal Disease

In a renal impairment study, venlafaxine elimination half-life after oral administration was prolonged by about 50% and clearance was reduced by about 24% in renally impaired patients (GFR = 10-70 mL/min), compared to normal subjects. In dialysis patients, venlafaxine elimination half-life was prolonged by about 180% and clearance was reduced by about 57% compared to normal subjects. Similarly, ODV elimination half-life was prolonged by about 40% although clearance was unchanged in patients with renal impairment (GFR = 10-70 mL/min) compared to normal subjects. In dialysis patients, ODV elimination half-life was prolonged by about 142% and clearance was reduced by about 56%, compared to normal subjects. A large degree of intersubject variability was noted.

Dosage adjustment is necessary in these patients (see **DOSAGE AND ADMINISTRATION**).

CLINICAL TRIALS

The efficacy of Effexor (venlafaxine hydrochloride) as a treatment for depression was established in 5 placebo-controlled, short-term trials. Four of these were 6-week trials in outpatients meeting DSM-III or DSM-III-R criteria for major depression: two involving dose titration with Effexor in a range of 75 to 225 mg/day (t.i.d. schedule), the third involving fixed Effexor doses of 75, 225, and 375 mg/day (t.i.d. schedule), and the fourth involving doses of 25, 75, and 200 mg/day (b.i.d. schedule). The fifth was a 4-week study of inpatients meeting DSM-III-R criteria for major depression with melancholia whose Effexor doses were titrated in a range of 150 to 375 mg/day (t.i.d. schedule). In these 5 studies, Effexor was shown to be significantly superior to placebo on at least 2 of the following 3 measures: Hamilton Depression Rating Scale (total score), Hamilton depressed mood item, and Clinical Global Impression-Severity of Illness rating. Doses from 75 to 225 mg/day were superior to placebo in outpatient studies and a mean dose of about 350 mg/day was effective in inpatients. Data from the 2 fixed-dose outpatient studies were suggestive of a dose-response relationship in the range of 75 to 225 mg/day. There was no suggestion of increased response with doses greater than 225 mg/day.

While there were no efficacy studies focusing specifically on an elderly population, elderly patients were included among the patients studied. Overall, approximately 2/3 of all patients in these trials were women. Exploratory analyses for age and gender effects on outcome did not suggest any differential responsiveness on the basis of age or sex.

In one longer-term study, outpatients meeting DSM-IV criteria for major depressive disorder who had responded during an 8-week open trial on Effexor XR (75, 150, or 225 mg, qAM) were randomized to continuation of their same Effexor XR dose or to placebo, for up to 26 weeks of observation for relapse. Response during the open phase was defined as a CGI Severity of Illness item score of ≤ 3 and a HAM-D-21 total score of ≤ 10 at the day 56 evaluation. Relapse during the double-blind phase was defined as follows: (1) a reappearance of major depressive disorder as defined by DSM-IV criteria and a CGI Severity of Illness item score of ≥ 4 (moderately ill), (2) 2 consecutive CGI Severity of Illness item scores of ≥ 4 , or (3) a final CGI Severity of Illness item score of ≥ 4 for any patient who withdrew from the study for any reason. Patients receiving continued Effexor XR treatment experienced significantly lower relapse rates over the subsequent 26 weeks compared with those receiving placebo.

In a second longer-term trial, outpatients meeting DSM-III-R criteria for major depressive disorder, recurrent type, who had responded (HAM-D-21 total score ≤ 12 at the day 56 evaluation) and continued to be improved [defined as the following criteria being met for days 56 through 180: (1) no HAM-D-21 total score ≥ 20 ; (2) no more than 2 HAM-D-21 total scores > 10 ; and (3) no single CGI Severity of Illness item score ≥ 4 (moderately ill)] during an initial 26 weeks of treatment on Effexor (100 to 200 mg/day, on a b.i.d. schedule) were randomized to continuation of their same Effexor dose or to placebo. The follow-up period to observe patients for relapse, defined as a CGI Severity of Illness item score ≥ 4 , was for up to 52 weeks. Patients receiving continued Effexor treatment experienced significantly lower relapse rates over the subsequent 52 weeks compared with those receiving placebo.

INDICATIONS AND USAGE

Effexor (venlafaxine hydrochloride) is indicated for the treatment of depression.

The efficacy of Effexor in the treatment of depression was established in 6-week controlled trials of outpatients whose diagnoses corresponded most closely to the DSM-III or DSM-III-R category of major depressive disorder and in a 4-week controlled trial of inpatients meeting diagnostic criteria for major depressive disorder with melancholia (see **CLINICAL TRIALS**).

A major depressive episode implies a prominent and relatively persistent depressed or dysphoric mood that usually interferes with daily functioning (nearly every day for at least 2 weeks); it should include at least 4 of the following 8 symptoms: change in appetite, change in sleep, psychomotor agitation or retardation, loss of interest in usual activities or decrease in sexual drive, increased fatigue, feelings of guilt or worthlessness, slowed thinking or impaired concentration, and a suicide attempt or suicidal ideation.

The efficacy of Effexor XR in maintaining an antidepressant response for up to 26 weeks following 8 weeks of acute treatment was demonstrated in a placebo-controlled trial. The efficacy of Effexor in maintaining an antidepressant response in patients with recurrent depression who had responded and continued to be improved during an initial 26 weeks of treatment and were then followed for a period of up to 52 weeks was demonstrated in a second placebo-controlled trial (see **CLINICAL TRIALS**). Nevertheless, the physician who elects to use Effexor/Effexor XR for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

CONTRAINDICATIONS

Hypersensitivity to venlafaxine hydrochloride or to any excipients in the formulation.

Concomitant use in patients taking monoamine oxidase inhibitors (MAOIs) is contraindicated (see **WARNINGS**).

WARNINGS

Potential for Interaction with Monoamine Oxidase Inhibitors

Adverse reactions, some of which were serious, have been reported in patients who have recently been discontinued from a monoamine oxidase inhibitor (MAOI) and started on Effexor, or who have recently had Effexor therapy discontinued prior to initiation of an MAOI. These reactions have included tremor, myoclonus, diaphoresis, nausea, vomiting, flushing, dizziness, hyperthermia with features resembling neuroleptic malignant syndrome, seizures, and death. In patients receiving antidepressants with pharmacological properties similar to venlafaxine in combination with a monoamine oxidase inhibitor, there have also been reports of serious, sometimes fatal, reactions. For a selective serotonin reuptake inhibitor, these reactions have included hyperthermia, rigidity, myoclonus, autonomic instability with possible rapid fluctuations of vital signs, and mental status changes that include extreme agitation progressing to delirium and coma. Some cases presented with features resembling neuroleptic malignant syndrome. Severe hyperthermia and seizures, sometimes fatal, have been reported in association with the combined use of tricyclic antidepressants and MAOIs. These reactions have also been reported in patients who have recently discontinued these drugs and have been started on an MAOI. Therefore, it is recommended that Effexor not be used in combination with an MAOI, or within at least 14 days of discontinuing treatment with an MAOI. Based on the half-life of Effexor, at least 7 days should be allowed after stopping Effexor before starting an MAOI.

Sustained Hypertension

Venlafaxine treatment is associated with sustained increases in blood pressure in some patients.

(1) In a premarketing study comparing three fixed doses of venlafaxine (75, 225, and 375 mg/day) and placebo, a mean increase in supine diastolic blood pressure (SDBP) of 7.2 mm Hg was seen in the 375 mg/day group at week 6 compared to essentially no changes in the 75 and 225 mg/day groups and a mean decrease in SDBP of 2.2 mm Hg in the placebo group. (2) An analysis for patients meeting criteria for sustained hypertension (defined as treatment-emergent SDBP ≥ 90 mm Hg *and* ≥ 10 mm Hg above baseline for 3 consecutive visits) revealed a dose-dependent increase in the incidence of sustained hypertension for venlafaxine:

Probability of Sustained Elevation in SDBP (Pool of Premarketing Venlafaxine Studies)	
Treatment Group	Incidence of Sustained Elevation in SDBP
Venlafaxine	
< 100 mg/day	3%
101-200 mg/day	5%
201-300 mg/day	7%
> 300 mg/day	13%
Placebo	2%

An analysis of the patients with sustained hypertension and the 19 venlafaxine patients who were discontinued from treatment because of hypertension (<1% of total venlafaxine-treated group) revealed that most of the blood pressure increases were in a modest range (10 to 15 mm Hg, SDBP). Nevertheless, sustained increases of this magnitude could have adverse consequences. Therefore, it is recommended that patients receiving venlafaxine have regular monitoring of blood pressure. For patients who experience a sustained increase in blood pressure while receiving venlafaxine, either dose reduction or discontinuation should be considered.

PRECAUTIONS

General

Anxiety and Insomnia

Treatment-emergent anxiety, nervousness, and insomnia were more commonly reported for venlafaxine-treated patients compared to placebo-treated patients in a pooled analysis of short-term, double-blind, placebo-controlled depression studies:

<u>Symptom</u>	<u>Venlafaxine</u> <u>n = 1033</u>	<u>Placebo</u> <u>n = 609</u>
Anxiety	6%	3%
Nervousness	13%	6%
Insomnia	18%	10%

Anxiety, nervousness, and insomnia led to drug discontinuation in 2%, 2%, and 3%, respectively, of the patients treated with venlafaxine in the Phase 2 and Phase 3 depression studies.

Changes in Appetite and Weight

Treatment-emergent anorexia was more commonly reported for venlafaxine-treated (11%) than placebo-treated patients (2%) in the pool of short-term, double-blind, placebo-controlled depression studies. A dose-dependent weight loss was often noted in patients treated with venlafaxine for several weeks. Significant weight loss, especially in underweight depressed patients, may be an undesirable result of venlafaxine treatment. A loss of 5% or more of body weight occurred in 6% of patients treated with venlafaxine compared with 1% of patients treated with placebo and 3% of patients treated with another antidepressant. However, discontinuation for weight loss associated with venlafaxine was uncommon (0.1% of venlafaxine-treated patients in the Phase 2 and Phase 3 depression trials).

The safety and efficacy of venlafaxine therapy in combination with weight loss agents, including phentermine, have not been established. Co-administration of Effexor and weight loss agents is not recommended. Effexor is not indicated for weight loss alone or in combination with other products.

Effexor has not been evaluated or used to any appreciable extent in patients with a recent history of myocardial infarction or unstable heart disease. Patients with these diagnoses were systematically excluded from many clinical studies during the product's premarketing testing. Evaluation of the electrocardiograms for 769 patients who received Effexor in 4- to 6-week double-blind placebo-controlled trials, however, showed that the incidence of trial-emergent conduction abnormalities did not differ from that with placebo. The mean heart rate in Effexor-treated patients was increased relative to baseline by about 4 beats per minute.

The electrocardiograms for 357 patients who received Effexor XR (the extended-release form of venlafaxine) and 285 patients who received placebo in 8- to 12-week double-blind, placebo-controlled trials were analyzed. The mean change from baseline in corrected QT interval (QTc) for Effexor XR-treated patients was increased relative to that for placebo-treated patients (increase of 4.7 msec for Effexor XR and decrease of 1.9 msec for placebo). In these same trials, the mean change from baseline in heart rate for Effexor XR-treated patients was significantly higher than that for placebo (a mean increase of 4 beats per minute for Effexor XR and 1 beat per minute for placebo). In a flexible-dose study, with Effexor doses in the range of 200 to 375 mg/day and mean dose greater than 300 mg/day, Effexor-treated patients had a mean increase in heart rate of 8.5 beats per minute compared with 1.7 beats per minute in the placebo group.

As increases in heart rate were observed, caution should be exercised in patients whose underlying medical conditions might be compromised by increases in heart rate (eg, patients with hyperthyroidism, heart failure, or recent myocardial infarction), particularly when using doses of Effexor above 200 mg/day.

In patients with renal impairment (GFR=10 to 70 mL/min) or cirrhosis of the liver, the clearances of venlafaxine and its active metabolite were decreased, thus prolonging the elimination half-lives of these substances. A lower dose may be necessary (see **DOSAGE AND ADMINISTRATION**). Effexor (venlafaxine hydrochloride), like all antidepressants, should be used with caution in such patients.

Information for Patients

Physicians are advised to discuss the following issues with patients for whom they prescribe Effexor:

Interference with Cognitive and Motor Performance

Clinical studies were performed to examine the effects of venlafaxine on behavioral performance of healthy individuals. The results revealed no clinically significant impairment of psychomotor, cognitive, or complex behavior performance. However, since any psychoactive drug may impair judgment, thinking, or motor skills, patients should be cautioned about operating hazardous machinery, including automobiles, until they are reasonably certain that Effexor therapy does not adversely affect their ability to engage in such activities.

Pregnancy

Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy.

Nursing

Patients should be advised to notify their physician if they are breast-feeding an infant.

Concomitant Medication

Patients should be advised to inform their physicians if they are taking, or plan to take, any prescription or over-the-counter drugs, including herbal preparations, since there is a potential for interactions.

Alcohol

Although Effexor has not been shown to increase the impairment of mental and motor skills caused by alcohol, patients should be advised to avoid alcohol while taking Effexor.

Allergic Reactions

Patients should be advised to notify their physician if they develop a rash, hives, or a related allergic phenomenon.

Laboratory Tests

There are no specific laboratory tests recommended.

Drug Interactions

As with all drugs, the potential for interaction by a variety of mechanisms is a possibility.

Alcohol

A single dose of ethanol (0.5 g/kg) had no effect on the pharmacokinetics of venlafaxine or ODV when venlafaxine was administered at 150 mg/day in 15 healthy male subjects. Additionally, administration of venlafaxine in a stable regimen did not exaggerate the psychomotor and psychometric effects induced by ethanol in these same subjects when they were not receiving venlafaxine.

Cimetidine

Concomitant administration of cimetidine and venlafaxine in a steady-state study for both drugs resulted in inhibition of first-pass metabolism of venlafaxine in 18 healthy subjects. The oral clearance of venlafaxine was reduced by about 43%, and the exposure (AUC) and maximum concentration (C_{max}) of the drug were increased by about 60%. However, co-administration of cimetidine had no apparent effect on the pharmacokinetics of ODV, which is present in much greater quantity in the circulation than is venlafaxine. The overall pharmacological activity of venlafaxine plus ODV is expected to increase only slightly, and no dosage adjustment should be necessary for most normal adults. However, for patients with pre-existing hypertension, and for elderly patients or patients with hepatic dysfunction, the interaction associated with the concomitant use of venlafaxine and cimetidine is not known and potentially could be more pronounced. Therefore, caution is advised with such patients.

Diazepam

Under steady-state conditions for venlafaxine administered at 150 mg/day, a single 10 mg dose of diazepam did not appear to affect the pharmacokinetics of either venlafaxine or ODV in 18 healthy male subjects. Venlafaxine also did not have any effect on the pharmacokinetics of diazepam or its active metabolite, desmethyldiazepam, or affect the psychomotor and psychometric effects induced by diazepam.

Haloperidol

Venlafaxine administered under steady-state conditions at 150 mg/day in 24 healthy subjects decreased total oral-dose clearance (Cl/F) of a single 2 mg dose of haloperidol by 42%, which resulted in a 70% increase in haloperidol AUC. In addition, the haloperidol C_{max} increased 88% when coadministered with venlafaxine, but the haloperidol elimination half-life (t_{1/2}) was unchanged. The mechanism explaining this finding is unknown.

Lithium

The steady-state pharmacokinetics of venlafaxine administered at 150 mg/day were not affected when a single 600 mg oral dose of lithium was administered to 12 healthy male subjects. O-desmethylvenlafaxine (ODV) also was unaffected. Venlafaxine had no effect on the pharmacokinetics of lithium (see also *CNS-Active Drugs*, below).

Drugs Highly Bound to Plasma Protein

Venlafaxine is not highly bound to plasma proteins; therefore, administration of Effexor to a patient taking another drug that is highly protein bound should not cause increased free concentrations of the other drug.

Drugs that Inhibit Cytochrome P450 Isoenzymes

CYP2D6 Inhibitors: In vitro and in vivo studies indicate that venlafaxine is metabolized to its active metabolite, ODV, by CYP2D6, the isoenzyme that is responsible for the genetic polymorphism seen in the metabolism of many antidepressants. Therefore, the potential exists for a drug interaction between drugs that inhibit CYP2D6-mediated metabolism and venlafaxine. However, although imipramine partially inhibited the CYP2D6-mediated metabolism of venlafaxine, resulting in higher plasma concentrations of venlafaxine and lower plasma concentrations of ODV, the total concentration of active compounds (venlafaxine plus ODV) was not affected. Additionally, in a clinical study involving CYP2D6-poor and -extensive metabolizers, the total concentration of active compounds (venlafaxine plus ODV), was similar in the two metabolizer groups. Therefore, no dosage adjustment is required when venlafaxine is coadministered with a CYP2D6 inhibitor.

CYP3A4 Inhibitors: In vitro studies indicate that venlafaxine is likely metabolized to a minor, less active metabolite, N-desmethylvenlafaxine, by CYP3A4. Because CYP3A4 is typically a minor pathway relative to CYP2D6 in the metabolism of venlafaxine, the potential for a clinically significant drug interaction between drugs that inhibit CYP3A4-mediated metabolism and venlafaxine is small.

The concomitant use of venlafaxine with a drug treatment(s) that potently inhibits both CYP2D6 and CYP3A4, the primary metabolizing enzymes for venlafaxine, has not been studied. Therefore, caution is advised should a patient's therapy include venlafaxine and any agent(s) that produce potent simultaneous inhibition of these two enzyme systems.

Drugs Metabolized by Cytochrome P450 Isoenzymes

CYP2D6: In vitro studies indicate that venlafaxine is a relatively weak inhibitor of CYP2D6. These findings have been confirmed in a clinical drug interaction study comparing the effect of venlafaxine to that of fluoxetine on the CYP2D6-mediated metabolism of dextromethorphan to dextrorphan.

Imipramine—Venlafaxine did not affect the pharmacokinetics of imipramine and 2-OH-imipramine. However, desipramine AUC, C_{max} , and C_{min} increased by about 35% in the presence of venlafaxine. The 2-OH-desipramine AUCs increased by at least 2.5 fold (with venlafaxine 37.5 mg q12h) and by 4.5 fold (with venlafaxine 75 mg q12h). Imipramine did not affect the pharmacokinetics of venlafaxine and ODV. The clinical significance of elevated 2-OH-desipramine levels is unknown.

Risperidone—Venlafaxine administered under steady-state conditions at 150 mg/day slightly inhibited the CYP2D6-mediated metabolism of risperidone (administered as a single 1 mg oral dose) to its active metabolite, 9-hydroxyrisperidone, resulting in an approximate 32% increase in risperidone AUC. However, venlafaxine coadministration did not significantly alter the pharmacokinetic profile of the total active moiety (risperidone plus 9-hydroxyrisperidone).

CYP3A4: Venlafaxine did not inhibit CYP3A4 in vitro. This finding was confirmed in vivo by clinical drug interaction studies in which venlafaxine did not inhibit the metabolism of several CYP3A4 substrates, including alprazolam, diazepam, and terfenadine.

Indinavir—In a study of 9 healthy volunteers, venlafaxine administered under steady-state conditions at 150 mg/day resulted in a 28% decrease in the AUC of a single 800 mg oral dose of indinavir and a 36% decrease in indinavir C_{max} . Indinavir did not affect the pharmacokinetics of venlafaxine and ODV. The clinical significance of this finding is unknown.

CYP1A2: Venlafaxine did not inhibit CYP1A2 in vitro. This finding was confirmed in vivo by a clinical drug interaction study in which venlafaxine did not inhibit the metabolism of caffeine, a CYP1A2 substrate.

CYP2C9: Venlafaxine did not inhibit CYP2C9 in vitro. The clinical significance of this finding is unknown.

CYP2C19: Venlafaxine did not inhibit the metabolism of diazepam which is partially metabolized by CYP2C19 (see *Diazepam* above).

Monoamine Oxidase Inhibitors

See **CONTRAINDICATIONS** and **WARNINGS**.

CNS-Active Drugs

Based on the mechanism of action of venlafaxine and the potential for serotonin syndrome, caution is advised when venlafaxine is co-administered with other drugs that may affect the serotonergic neurotransmitter systems, such as triptans, serotonin reuptake inhibitors (SRIs), or lithium.

Electroconvulsive Therapy

There are no clinical data establishing the benefit of electroconvulsive therapy combined with Effexor treatment.

Postmarketing Spontaneous Drug Interaction Reports

See **ADVERSE REACTIONS, Postmarketing Reports**.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis

Venlafaxine was given by oral gavage to mice for 18 months at doses up to 120 mg/kg per day, which was 16 times, on a mg/kg basis, and 1.7 times on a mg/m² basis, the maximum recommended human dose. Venlafaxine was also given to rats by oral gavage for 24 months at doses up to 120 mg/kg per day. In rats receiving the 120 mg/kg dose, plasma levels of venlafaxine were 1 times (male rats) and 6 times (female rats) the plasma levels of patients receiving the maximum recommended human dose. Plasma levels of the O-desmethyl metabolite were lower in rats than in patients receiving the maximum recommended dose. Tumors were not increased by venlafaxine treatment in mice or rats.

Mutagenicity

Venlafaxine and the major human metabolite, O-desmethylvenlafaxine (ODV), were not mutagenic in the Ames reverse mutation assay in *Salmonella* bacteria or the CHO/HGPRT mammalian cell forward gene mutation assay. Venlafaxine was also not mutagenic in the in vitro BALB/c-3T3 mouse cell transformation assay, the sister chromatid exchange assay in cultured CHO cells, or the in vivo chromosomal aberration assay in rat bone marrow. ODV was not mutagenic in the in vitro CHO cell chromosomal aberration assay. There was a clastogenic response in the in vivo chromosomal aberration assay in rat bone marrow in male rats receiving 200 times, on a mg/kg basis, or 50 times, on a mg/m² basis, the maximum human daily dose. The no effect dose was 67 times (mg/kg) or 17 times (mg/m²) the human dose.

Impairment of Fertility

Reproduction and fertility studies in rats showed no effects on male or female fertility at oral doses of up to 8 times the maximum recommended human daily dose on a mg/kg basis, or up to 2 times on a mg/m² basis.

Pregnancy

Teratogenic Effects—Pregnancy Category C

Venlafaxine did not cause malformations in offspring of rats or rabbits given doses up to 11 times (rat) or 12 times (rabbit) the maximum recommended human daily dose on a mg/kg basis, or 2.5 times (rat) and 4 times (rabbit) the human daily dose on a mg/m² basis. However, in rats, there was a decrease in pup weight, an increase in stillborn pups, and an increase in pup deaths during the first 5 days of lactation, when dosing began during pregnancy and continued until weaning. The cause of these deaths is not known. These effects occurred at 10 times (mg/kg) or 2.5 times (mg/m²) the maximum human daily dose. The no effect dose for rat pup mortality was 1.4 times the human dose on a mg/kg basis or 0.25 times the human dose on a mg/m² basis. There are no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Non-teratogenic Effects

If venlafaxine is used until or shortly before birth, discontinuation effects in the newborn should be considered.

Labor and Delivery

The effect of Effexor[®] (venlafaxine hydrochloride) on labor and delivery in humans is unknown.

Nursing Mothers

Venlafaxine and ODV have been reported to be excreted in human milk. Because of the potential for serious adverse reactions in nursing infants from Effexor, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Usage in Children

Safety and effectiveness in individuals below 18 years of age have not been established.

In pediatric clinical trials, there were increased reports of hostility and, especially in Major Depressive Disorder, suicide-related adverse events such as suicidal ideation and self-harm.

Geriatric Use

Of the 2,897 patients in Phase 2 and Phase 3 depression studies with Effexor, 12% (357) were 65 years of age or over. No overall differences in effectiveness or safety were observed between these patients and younger patients, and other reported clinical experience generally has not identified differences in response between the elderly and younger patients. However, greater sensitivity of some older individuals cannot be ruled out. As with other antidepressants, several cases of hyponatremia and syndrome of inappropriate antidiuretic hormone secretion (SIADH) have been reported, usually in the elderly.

The pharmacokinetics of venlafaxine and ODV are not substantially altered in the elderly (see **CLINICAL PHARMACOLOGY**). No dose adjustment is recommended for the elderly on the basis of age alone, although other clinical circumstances, some of which may be more common in the elderly, such as renal or hepatic impairment, may warrant a dose reduction (see **DOSAGE AND ADMINISTRATION**).

ADVERSE REACTIONS

Associated with Discontinuation of Treatment

Nineteen percent (537/2897) of venlafaxine patients in Phase 2 and Phase 3 depression studies discontinued treatment due to an adverse event. The more common events ($\geq 1\%$) associated with discontinuation and considered to be drug-related (ie, those events associated with dropout at a rate approximately twice or greater for venlafaxine compared to placebo) included:

<u>CNS</u>	<u>Venlafaxine</u>	<u>Placebo</u>
Somnolence	3%	1%
Insomnia	3%	1%
Dizziness	3%	—
Nervousness	2%	—
Dry mouth	2%	—
Anxiety	2%	1%
<u>Gastrointestinal</u>		
Nausea	6%	1%
<u>Urogenital</u>		
Abnormal ejaculation*	3%	—

Other

Headache	3%	1%
Asthenia	2%	—
Sweating	2%	—

* Percentages based on the number of males.

— Less than 1%

Incidence in Controlled Trials

Commonly Observed Adverse Events in Controlled Clinical Trials

The most commonly observed adverse events associated with the use of Effexor® (incidence of 5% or greater) and not seen at an equivalent incidence among placebo-treated patients (ie, incidence for Effexor at least twice that for placebo), derived from the 1% incidence table below, were asthenia, sweating, nausea, constipation, anorexia, vomiting, somnolence, dry mouth, dizziness, nervousness, anxiety, tremor, and blurred vision as well as abnormal ejaculation/orgasm and impotence in men.

Adverse Events Occurring at an Incidence of 1% or More Among Effexor-Treated Patients

The table that follows enumerates adverse events that occurred at an incidence of 1% or more, and were more frequent than in the placebo group, among Effexor-treated patients who participated in short-term (4- to 8-week) placebo-controlled trials in which patients were administered doses in a range of 75 to 375 mg/day. This table shows the percentage of patients in each group who had at least one episode of an event at some time during their treatment. Reported adverse events were classified using a standard COSTART-based Dictionary terminology.

The prescriber should be aware that these figures cannot be used to predict the incidence of side effects in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and nondrug factors to the side effect incidence rate in the population studied.

TABLE 1
Treatment-Emergent Adverse Experience Incidence in 4- to 8-Week Placebo-Controlled Clinical Trials¹

Body System	Preferred Term	Effexor (n=1033)	Placebo (n=609)
Body as a Whole	Headache	25%	24%
	Asthenia	12%	6%
	Infection	6%	5%
	Chills	3%	—
	Chest pain	2%	1%
	Trauma	2%	1%

Body System	Preferred Term	Effexor (n=1033)	Placebo (n=609)
Cardiovascular	Vasodilatation	4%	3%
	Increased blood pressure/hypertension	2%	—
	Tachycardia	2%	—
	Postural hypotension	1%	—
Dermatological	Sweating	12%	3%
	Rash	3%	2%
	Pruritus	1%	—
Gastrointestinal	Nausea	37%	11%
	Constipation	15%	7%
	Anorexia	11%	2%
	Diarrhea	8%	7%
	Vomiting	6%	2%
	Dyspepsia	5%	4%
	Flatulence	3%	2%
Metabolic	Weight loss	1%	—
Nervous System	Somnolence	23%	9%
	Dry mouth	22%	11%
	Dizziness	19%	7%
	Insomnia	18%	10%
	Nervousness	13%	6%
	Anxiety	6%	3%
	Tremor	5%	1%
	Abnormal dreams	4%	3%
	Hypertonia	3%	2%
	Paresthesia	3%	2%
	Libido decreased	2%	—
	Agitation	2%	—
	Confusion	2%	1%
	Thinking abnormal	2%	1%
	Depersonalization	1%	—
	Depression	1%	—
	Urinary retention	1%	—
	Twitching	1%	—
Respiration	Yawn	3%	—
Special Senses	Blurred vision	6%	2%
	Taste perversion	2%	—
	Tinnitus	2%	—
	Mydriasis	2%	—

Body System	Preferred Term	Effexor (n=1033)	Placebo (n=609)
Urogenital System	Abnormal ejaculation/ orgasm	12% ²	— ²
	Impotence	6% ²	— ²
	Urinary frequency	3%	2%
	Urination impaired	2%	—
	Orgasm disturbance	2% ³	— ³

¹ Events reported by at least 1% of patients treated with Effexor (venlafaxine hydrochloride) are included, and are rounded to the nearest %. Events for which the Effexor incidence was equal to or less than placebo are not listed in the table, but included the following: abdominal pain, pain, back pain, flu syndrome, fever, palpitation, increased appetite, myalgia, arthralgia, amnesia, hypesthesia, rhinitis, pharyngitis, sinusitis, cough increased, and dysmenorrhea³.

— Incidence less than 1%.

² Incidence based on number of male patients.

³ Incidence based on number of female patients.

Dose Dependency of Adverse Events

A comparison of adverse event rates in a fixed-dose study comparing Effexor (venlafaxine hydrochloride) 75, 225, and 375 mg/day with placebo revealed a dose dependency for some of the more common adverse events associated with Effexor use, as shown in the table that follows. The rule for including events was to enumerate those that occurred at an incidence of 5% or more for at least one of the venlafaxine groups and for which the incidence was at least twice the placebo incidence for at least one Effexor group. Tests for potential dose relationships for these events (Cochran-Armitage Test, with a criterion of exact 2-sided p-value ≤ 0.05) suggested a dose-dependency for several adverse events in this list, including chills, hypertension, anorexia, nausea, agitation, dizziness, somnolence, tremor, yawning, sweating, and abnormal ejaculation.

TABLE 2
Treatment-Emergent Adverse Experience Incidence in a Dose Comparison Trial
Effexor (mg/day)

Body System/ Preferred Term	Placebo (n=92)	75 (n=89)	225 (n=89)	375 (n=88)
Body as a Whole				
Abdominal pain	3.3%	3.4%	2.2%	8.0%
Asthenia	3.3%	16.9%	14.6%	14.8%
Chills	1.1%	2.2%	5.6%	6.8%
Infection	2.2%	2.2%	5.6%	2.3%
Cardiovascular System				
Hypertension	1.1%	1.1%	2.2%	4.5%
Vasodilatation	0.0%	4.5%	5.6%	2.3%
Digestive System				
Anorexia	2.2%	14.6%	13.5%	17.0%
Dyspepsia	2.2%	6.7%	6.7%	4.5%
Nausea	14.1%	32.6%	38.2%	58.0%
Vomiting	1.1%	7.9%	3.4%	6.8%

Body System/ Preferred Term	Effexor (mg/day)			
	Placebo (n=92)	75 (n=89)	225 (n=89)	375 (n=88)
Nervous System				
Agitation	0.0%	1.1%	2.2%	4.5%
Anxiety	4.3%	11.2%	4.5%	2.3%
Dizziness	4.3%	19.1%	22.5%	23.9%
Insomnia	9.8%	22.5%	20.2%	13.6%
Libido decreased	1.1%	2.2%	1.1%	5.7%
Nervousness	4.3%	21.3%	13.5%	12.5%
Somnolence	4.3%	16.9%	18.0%	26.1%
Tremor	0.0%	1.1%	2.2%	10.2%
Respiratory System				
Yawn	0.0%	4.5%	5.6%	8.0%
Skin and Appendages				
Sweating	5.4%	6.7%	12.4%	19.3%
Special Senses				
Abnormality of accommodation	0.0%	9.1%	7.9%	5.6%
Urogenital System				
Abnormal ejaculation/orgasm	0.0%	4.5%	2.2%	12.5%
Impotence	0.0%	5.8%	2.1%	3.6%
(Number of men)	(n=63)	(n=52)	(n=48)	(n=56)

Adaptation to Certain Adverse Events

Over a 6-week period, there was evidence of adaptation to some adverse events with continued therapy (eg, dizziness and nausea), but less to other effects (eg, abnormal ejaculation and dry mouth).

Vital Sign Changes

Effexor (venlafaxine hydrochloride) treatment (averaged over all dose groups) in clinical trials was associated with a mean increase in pulse rate of approximately 3 beats per minute, compared to no change for placebo. In a flexible-dose study, with doses in the range of 200 to 375 mg/day and mean dose greater than 300 mg/day, the mean pulse was increased by about 2 beats per minute compared with a decrease of about 1 beat per minute for placebo.

In controlled clinical trials, Effexor was associated with mean increases in diastolic blood pressure ranging from 0.7 to 2.5 mm Hg averaged over all dose groups, compared to mean decreases ranging from 0.9 to 3.8 mm Hg for placebo. However, there is a dose dependency for blood pressure increase (see **WARNINGS**).

Laboratory Changes

Of the serum chemistry and hematology parameters monitored during clinical trials with Effexor, a statistically significant difference with placebo was seen only for serum cholesterol. In premarketing trials, treatment with Effexor tablets was associated with a mean final on-therapy increase in total cholesterol of 3 mg/dL.

Patients treated with Effexor tablets for at least 3 months in placebo-controlled 12-month extension trials had a mean final on-therapy increase in total cholesterol of 9.1 mg/dL compared with a decrease of 7.1 mg/dL among placebo-treated patients. This increase was duration dependent over the study period and tended to be greater with higher doses. Clinically relevant increases in serum cholesterol, defined as 1) a final on-therapy increase in serum cholesterol ≥ 50 mg/dL from baseline and to a value ≥ 261 mg/dL or 2) an average on-therapy increase in serum cholesterol ≥ 50 mg/dL from baseline and to a value ≥ 261 mg/dL, were recorded in 5.3% of venlafaxine-treated patients and 0.0% of placebo-treated patients (see **PRECAUTIONS-General-Serum Cholesterol Elevation**).

ECG Changes

In an analysis of ECGs obtained in 769 patients treated with Effexor and 450 patients treated with placebo in controlled clinical trials, the only statistically significant difference observed was for heart rate, ie, a mean increase from baseline of 4 beats per minute for Effexor. In a flexible-dose study, with doses in the range of 200 to 375 mg/day and mean dose greater than 300 mg/day, the mean change in heart rate was 8.5 beats per minute compared with 1.7 beats per minute for placebo (see **PRECAUTIONS, General, Use in Patients with Concomitant Illness**).

Other Events Observed During the Premarketing Evaluation of Venlafaxine

During its premarketing assessment, multiple doses of Effexor were administered to 2897 patients in Phase 2 and Phase 3 studies. In addition, in premarketing assessment of Effexor XR (the extended release form of venlafaxine), multiple doses were administered to 705 patients in Phase 3 depression studies and Effexor was administered to 96 patients. During its premarketing assessment for Generalized Anxiety Disorder, multiple doses of Effexor XR were administered to 476 patients in Phase 3 studies. The conditions and duration of exposure to venlafaxine in both development programs varied greatly, and included (in overlapping categories) open and double-blind studies, uncontrolled and controlled studies, inpatient (Effexor only) and outpatient studies, fixed-dose and titration studies. Untoward events associated with this exposure were recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse events without first grouping similar types of untoward events into a smaller number of standardized event categories.

In the tabulations that follow, reported adverse events were classified using a standard COSTART-based Dictionary terminology. The frequencies presented, therefore, represent the proportion of the 4174 patients exposed to multiple doses of either formulation of venlafaxine who experienced an event of the type cited on at least one occasion while receiving venlafaxine. All reported events are included except those already listed in Table 1 and those events for which a drug cause was remote. If the COSTART term for an event was so general as to be uninformative, it was replaced with a more informative term. It is important to emphasize that,

although the events reported occurred during treatment with venlafaxine, they were not necessarily caused by it.

Events are further categorized by body system and listed in order of decreasing frequency using the following definitions: **frequent** adverse events are defined as those occurring on one or more occasions in at least 1/100 patients; **infrequent** adverse events are those occurring in 1/100 to 1/1000 patients; **rare** events are those occurring in fewer than 1/1000 patients.

Body as a whole—**Frequent:** chest pain substernal, neck pain; **Infrequent:** face edema, intentional injury, malaise, moniliasis, neck rigidity, pelvic pain, photosensitivity reaction, suicide attempt; **Rare:** appendicitis, bacteremia, carcinoma, cellulitis, withdrawal syndrome.

Cardiovascular system—**Frequent:** migraine; **Infrequent:** angina pectoris, arrhythmia, extrasystoles, hypotension, peripheral vascular disorder (mainly cold feet and/or cold hands), syncope, thrombophlebitis; **Rare:** aortic aneurysm, arteritis, first-degree atrioventricular block, bigeminy, bradycardia, bundle branch block, capillary fragility, cerebral ischemia, coronary artery disease, congestive heart failure, heart arrest, mitral valve disorder, mucocutaneous hemorrhage, myocardial infarct, pallor.

Digestive system—**Frequent:** crurtation; **Infrequent:** bruxism, colitis, dysphagia, tongue edema, esophagitis, gastritis, gastroenteritis, gastrointestinal ulcer, gingivitis, glossitis, rectal hemorrhage, hemorrhoids, melena, stomatitis, mouth ulceration; **Rare:** cheilitis, cholecystitis, cholelithiasis, hematemesis, gastrointestinal hemorrhage, gum hemorrhage, hepatitis, ileitis, jaundice, intestinal obstruction, oral moniliasis, proctitis, increased salivation, soft stools, tongue discoloration.

Endocrine system—**Rare:** goiter, hyperthyroidism, hypothyroidism, thyroid nodule, thyroiditis.

Hemic and lymphatic system—**Frequent:** ecchymosis; **Infrequent:** anemia, leukocytosis, leukopenia, lymphadenopathy, thrombocythemia, thrombocytopenia; **Rare:** basophilia, bleeding time increased, cyanosis, eosinophilia, lymphocytosis, multiple myeloma, purpura.

Metabolic and nutritional—**Frequent:** edema, weight gain; **Infrequent:** alkaline phosphatase increased, glycosuria, hypercholesteremia, hyperglycemia, hyperuricemia, hypoglycemia, hypokalemia, SGOT increased, thirst; **Rare:** alcohol intolerance, bilirubinemia, BUN increased, creatinine increased, diabetes mellitus, dehydration, gout, healing abnormal, hemochromatosis, hypercalcinuria, hyperkalemia, hyperlipemia, hyperphosphatemia, hyponatremia, hypophosphatemia, hypoproteinemia, SGPT increased, uremia.

Musculoskeletal system—**Infrequent:** arthritis, arthrosis, bone pain, bone spurs, bursitis, leg cramps, myasthenia, tenosynovitis; **Rare:** pathological fracture, myopathy, osteoporosis, osteosclerosis, rheumatoid arthritis, tendon rupture.

Nervous system—**Frequent:** emotional lability, trismus, vertigo; **Infrequent:** apathy, ataxia, circumoral paresthesia, CNS stimulation, euphoria, hallucinations, hostility, hyperesthesia, hyperkinesia, hypotonia, incoordination, libido increased, manic reaction, myoclonus, neuralgia, neuropathy, paranoid reaction, psychosis, seizure, abnormal speech, stupor; **Rare:** akathisia, akinesia, alcohol abuse, aphasia, bradykinesia, buccoglossal syndrome, cerebrovascular accident,

loss of consciousness, delusions, dementia, dystonia, facial paralysis, abnormal gait, Guillain-Barre Syndrome, hypokinesia, neuritis, nystagmus, paresis, psychotic depression, reflexes decreased, reflexes increased, suicidal ideation, torticollis.

Respiratory system—**Frequent:** bronchitis, dyspnea; **Infrequent:** asthma, chest congestion, epistaxis, hyperventilation, laryngismus, laryngitis, pneumonia, voice alteration; **Rare:** atelectasis, hemoptysis, hypoventilation, hypoxia, larynx edema, pleurisy, pulmonary embolus, sleep apnea.

Skin and appendages—**Infrequent:** acne, alopecia, brittle nails, contact dermatitis, dry skin, eczema, skin hypertrophy, maculopapular rash, psoriasis, urticaria; **Rare:** erythema nodosum, exfoliative dermatitis, lichenoid dermatitis, hair discoloration, skin discoloration, furunculosis, hirsutism, leukoderma, pustular rash, vesiculobullous rash, seborrhea, skin atrophy, skin striae.

Special senses—**Frequent:** abnormality of accommodation, abnormal vision; **Infrequent:** cataract, conjunctivitis, corneal lesion, diplopia, dry eyes, exophthalmos, eye pain, hyperacusis, otitis media, parosmia, photophobia, taste loss, visual field defect; **Rare:** blepharitis, chromatopsia, conjunctival edema, deafness, glaucoma, retinal hemorrhage, subconjunctival hemorrhage, keratitis, labyrinthitis, miosis, papilledema, decreased pupillary reflex, otitis externa, scleritis, uveitis.

Urogenital system—**Frequent:** metrorrhagia*, prostatitis*, vaginitis*; **Infrequent:** albuminuria, amenorrhea*, cystitis, dysuria, hematuria, female lactation*, leukorrhea*, menorrhagia*, nocturia, bladder pain, breast pain, polyuria, pyuria, urinary incontinence, urinary urgency, vaginal hemorrhage*; **Rare:** abortion*, anuria, breast discharge, breast engorgement, breast enlargement, endometriosis*, fibrocystic breast, calcium crystalluria, cervicitis*, ovarian cyst*, prolonged erection*, gynecomastia (male)*, hypomenorrhea*, kidney calculus, kidney pain, kidney function abnormal, mastitis, menopause*, pyelonephritis, oliguria, salpingitis*, urolithiasis, uterine hemorrhage*, uterine spasm.*

* Based on the number of men and women as appropriate.

Postmarketing Reports

Voluntary reports of other adverse events temporally associated with the use of venlafaxine that have been received since market introduction and that may have no causal relationship with the use of venlafaxine include the following: agranulocytosis, anaphylaxis, aplastic anemia, catatonia, congenital anomalies, CPK increased, deep vein thrombophlebitis, delirium, EKG abnormalities such as QT prolongation; cardiac arrhythmias including atrial fibrillation, supraventricular tachycardia, ventricular extrasystole, and rare reports of ventricular fibrillation and ventricular tachycardia, including torsade de pointes; epidermal necrosis/Stevens-Johnson Syndrome, erythema multiforme, extrapyramidal symptoms (including dyskinesia and tardive dyskinesia), hemorrhage (including eye and gastrointestinal bleeding), hepatic events (including GGT elevation; abnormalities of unspecified liver function tests; liver damage, necrosis, or failure; and fatty liver), involuntary movements, LDH increased, neuroleptic malignant syndrome-like events (including a case of a 10-year-old who may have been taking methylphenidate, was treated and recovered), neutropenia, night sweats, pancreatitis, pancytopenia, panic, prolactin increased, pulmonary eosinophilia, renal failure, rhabdomyolysis,

serotonin syndrome, shock-like electrical sensations (in some cases, subsequent to the discontinuation of venlafaxine or tapering of dose), and syndrome of inappropriate antidiuretic hormone secretion (usually in the elderly).

There have been reports of elevated clozapine levels that were temporally associated with adverse events, including seizures, following the addition of venlafaxine. There have been reports of increases in prothrombin time, partial thromboplastin time, or INR when venlafaxine was given to patients receiving warfarin therapy.

DRUG ABUSE AND DEPENDENCE

Controlled Substance Class

Effexor (venlafaxine hydrochloride) is not a controlled substance.

Physical and Psychological Dependence

In vitro studies revealed that venlafaxine has virtually no affinity for opiate, benzodiazepine, phencyclidine (PCP), or N-methyl-D-aspartic acid (NMDA) receptors.

Venlafaxine was not found to have any significant CNS stimulant activity in rodents. In primate drug discrimination studies, venlafaxine showed no significant stimulant or depressant abuse liability.

Discontinuation effects have been reported in patients receiving venlafaxine (see **DOSAGE AND ADMINISTRATION**).

While Effexor has not been systematically studied in clinical trials for its potential for abuse, there was no indication of drug-seeking behavior in the clinical trials. However, it is not possible to predict on the basis of premarketing experience the extent to which a CNS active drug will be misused, diverted, and/or abused once marketed. Consequently, physicians should carefully evaluate patients for history of drug abuse and follow such patients closely, observing them for signs of misuse or abuse of Effexor (eg, development of tolerance, incrementation of dose, drug-seeking behavior).

OVERDOSAGE

Human Experience

There were 14 reports of acute overdose with Effexor (venlafaxine hydrochloride), either alone or in combination with other drugs and/or alcohol, among the patients included in the premarketing evaluation. The majority of the reports involved ingestions in which the total dose of Effexor taken was estimated to be no more than several-fold higher than the usual therapeutic dose. The 3 patients who took the highest doses were estimated to have ingested approximately 6.75 g, 2.75 g, and 2.5 g. The resultant peak plasma levels of venlafaxine for the latter 2 patients were 6.24 and 2.35 µg/mL, respectively, and the peak plasma levels of O-desmethylvenlafaxine were 3.37 and 1.30 µg/mL, respectively. Plasma venlafaxine levels were not obtained for the patient who ingested 6.75 g of venlafaxine. All 14 patients recovered without sequelae. Most patients reported no symptoms. Among the remaining patients, somnolence was the most commonly reported symptom. The patient who ingested 2.75 g of venlafaxine was observed to have 2 generalized convulsions and a prolongation of QTc to 500 msec, compared with 405 msec at baseline. Mild sinus tachycardia was reported in 2 of the other patients.

In postmarketing experience, overdose with venlafaxine has occurred predominantly in combination with alcohol and/or other drugs. Electrocardiogram changes (eg, prolongation of QT interval, bundle branch block, QRS prolongation), sinus and ventricular tachycardia, bradycardia, hypotension, altered level of consciousness (ranging from somnolence to coma), seizures, vertigo, and death have been reported.

Management of Overdosage

Treatment should consist of those general measures employed in the management of overdose with any antidepressant.

Ensure an adequate airway, oxygenation, and ventilation. Monitor cardiac rhythm and vital signs. General supportive and symptomatic measures are also recommended. Induction of emesis is not recommended. Gastric lavage with a large-bore orogastric tube with appropriate airway protection, if needed, may be indicated if performed soon after ingestion or in symptomatic patients. Activated charcoal should be administered. Due to the large volume of distribution of this drug, forced diuresis, dialysis, hemoperfusion and exchange transfusion are unlikely to be of benefit. No specific antidotes for venlafaxine are known.

In managing overdose, consider the possibility of multiple drug involvement. The physician should consider contacting a poison control center for additional information on the treatment of any overdose. Telephone numbers for certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*.

DOSAGE AND ADMINISTRATION

Initial Treatment

The recommended starting dose for Effexor is 75 mg/day, administered in two or three divided doses, taken with food. Depending on tolerability and the need for further clinical effect, the dose may be increased to 150 mg/day. If needed, the dose should be further increased up to 225 mg/day. When increasing the dose, increments of up to 75 mg/day should be made at intervals of no less than 4 days. In outpatient settings there was no evidence of usefulness of doses greater than 225 mg/day for moderately depressed patients, but more severely depressed inpatients responded to a mean dose of 350 mg/day. Certain patients, including more severely depressed patients, may therefore respond more to higher doses, up to a maximum of 375 mg/day, generally in three divided doses (see **PRECAUTIONS, General, Use in Patients with Concomitant Illness**).

Dosage for Patients with Hepatic Impairment

Given the decrease in clearance and increase in elimination half-life for both venlafaxine and ODV that is observed in patients with hepatic cirrhosis compared to normal subjects (see **CLINICAL PHARMACOLOGY**), it is recommended that the total daily dose be reduced by 50% in patients with moderate hepatic impairment. Since there was much individual variability in clearance between patients with cirrhosis, it may be necessary to reduce the dose even more than 50%, and individualization of dosing may be desirable in some patients.

Dosage for Patients with Renal Impairment

Given the decrease in clearance for venlafaxine and the increase in elimination half-life for both venlafaxine and ODV that is observed in patients with renal impairment (GFR = 10 to 70 mL/min) compared to normals (see **CLINICAL PHARMACOLOGY**), it is recommended that the total daily dose be reduced by 25% in patients with mild to moderate renal impairment. It is recommended that the total daily dose be reduced by 50% and the dose be withheld until the dialysis treatment is completed (4 hrs) in patients undergoing hemodialysis. Since there was much individual variability in clearance between patients with renal impairment, individualization of dosing may be desirable in some patients.

Dosage for Elderly Patients

No dose adjustment is recommended for elderly patients on the basis of age. As with any antidepressant, however, caution should be exercised in treating the elderly. When individualizing the dosage, extra care should be taken when increasing the dose.

Maintenance Treatment

It is generally agreed that acute episodes of depression require several months or longer of sustained pharmacological therapy beyond response to the acute episode. In one study, in which patients responding during 8 weeks of acute treatment with Effexor XR were assigned randomly to placebo or to the same dose of Effexor XR (75, 150, or 225 mg/day, qAM) during 26 weeks of maintenance treatment as they had received during the acute stabilization phase, longer-term efficacy was demonstrated. A second longer-term study has demonstrated the efficacy of Effexor in maintaining an antidepressant response in patients with recurrent depression who had responded and continued to be improved during an initial 26 weeks of treatment and were then randomly assigned to placebo or Effexor for periods of up to 52 weeks on the same dose (100 to 200 mg/day, on a b.i.d. schedule) (see **CLINICAL TRIALS**). Based on these limited data, it is not known whether or not the dose of Effexor/Effexor XR needed for maintenance treatment is identical to the dose needed to achieve an initial response. Patients should be periodically reassessed to determine the need for maintenance treatment and the appropriate dose for such treatment.

Discontinuing Effexor (venlafaxine hydrochloride)

When discontinuing Effexor after more than 1 week of therapy, it is generally recommended that the dose be tapered to minimize the risk of discontinuation symptoms. Patients who have received Effexor for 6 weeks or more should have their dose tapered gradually over at least a 2-week period.

Discontinuation symptoms have been systematically evaluated in patients taking venlafaxine, to include prospective analyses of clinical trials in Generalized Anxiety Disorder and retrospective surveys of trials in depression. Abrupt discontinuation or dose reduction of venlafaxine at various doses has been found to be associated with the appearance of new symptoms, the frequency of which increased with increased dose level and with longer duration of treatment. Reported symptoms include agitation, anorexia, anxiety, confusion, coordination impaired, diarrhea, dizziness, dry mouth, dysphoric mood, fasciculation, fatigue, headaches, hypomania, insomnia, nausea, nervousness, nightmares, seizures, sensory disturbances (including shock-like electrical sensations), somnolence, sweating, tinnitus, tremor, vertigo, and vomiting. It is therefore recommended that the dosage of Effexor be tapered gradually and the patient

monitored. The period required for tapering may depend on the dose, duration of therapy and the individual patient. Discontinuation effects are well known to occur with antidepressants.

SWITCHING PATIENTS TO OR FROM A MONOAMINE OXIDASE INHIBITOR

At least 14 days should elapse between discontinuation of an MAOI and initiation of therapy with Effexor. In addition, at least 7 days should be allowed after stopping Effexor before starting an MAOI (see **CONTRAINDICATIONS** and **WARNINGS**).

HOW SUPPLIED

Effexor® (venlafaxine hydrochloride) Tablets are available as follows:

25 mg, peach, shield-shaped tablet with "25" and a "W" on one side and "701" on scored reverse side.

NDC 0008-0701-01, bottle of 100 tablets.

NDC 0008-0701-02, carton of 10 Redipak® blister strips of 10 tablets each.

37.5 mg, peach, shield-shaped tablet with "37.5" and a "W" on one side and "781" on scored reverse side.

NDC 0008-0781-01, bottle of 100 tablets.

NDC 0008-0781-02, carton of 10 Redipak® blister strips of 10 tablets each.

50 mg, peach, shield-shaped tablet with "50" and a "W" on one side and "703" on scored reverse side.

NDC 0008-0703-01, bottle of 100 tablets.

NDC 0008-0703-02, carton of 10 Redipak® blister strips of 10 tablets each.

75 mg, peach, shield-shaped tablet with "75" and a "W" on one side and "704" on scored reverse side.

NDC 0008-0704-01, bottle of 100 tablets.

NDC 0008-0704-02, carton of 10 Redipak® blister strips of 10 tablets each.

100 mg, peach, shield-shaped tablet with "100" and a "W" on one side and "705" on scored reverse side.

NDC 0008-0705-01, bottle of 100 tablets.

NDC 0008-0705-02, carton of 10 Redipak® blister strips of 10 tablets each.

The appearance of these tablets is a trademark of Wyeth-Ayerst Laboratories.

Store at controlled room temperature 20° to 25°C (68° to 77°F) in a dry place.

Dispense in a well-closed container as defined in the USP.



Wyeth Laboratories
A Wyeth-Ayerst Company
Philadelphia, PA 19101

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